

but preferred "...variations in pO₂, increase in partial oxygen pressure...". Reoxygenation was used only once (and should not have been) and we agree with Dr Stadler that an increase in pO₂ is not strictly reoxygenation and that the latter should never be used in clinical practice.

Finally, the relative change between well- and poorly-oxygenated areas of the tumours could be the most relevant parameter on clinical outcome. Whatever the biological significance of tumour pO₂ variations during treatment, it has been demonstrated that a correlation does exist between tumour pO₂ before treatment and clinical outcome in head and neck cervix tumours [9, 10]. It remains to be confirmed whether any variation in tumour oxygen tension during treatment plays a role in clinical outcome.

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Height and Breast Cancer Risk—the Bias of Self-reported Versus Measured Results. Comments on *Height and Breast Cancer Risk, Tavani et al., Eur J Cancer* 1998, **34**, 543–547

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TAVANI AND colleagues recently reported data from two case-control studies indicating no relationship between height and breast cancer risk [1]. The results were derived from 5984 cases and 5504 controls, admitted to hospital for non-hormone related diseases. All participants completed structured questionnaires in which information was sought on various personal characteristics and habits, including adult height and weight. When divided into quintiles, the odds ratio (OR) for breast cancer did not differ significantly from unity. After adjustment for study centre and age the OR of the tallest versus the shortest quintiles was 1.05 which fell to 0.96 after controlling for other potential confounding factors. For each 5 cm increment in height the OR was 0.98. As a result the authors concluded that adult height was not a breast cancer risk factor in Northern Italian women.

It is possible that in this study, as in many others, the investigators were the victim of inaccurate self-reporting of height. We have previously observed and reported this phenomenon, which became evident in the Guernsey study [2]. Two cohorts of ostensibly normal female volunteers were recruited between 1961–1968 (4923 women) and 1968–1976 (5149 women). In the earlier cohort, individual height was self-reported, whereas in the second group this was measured at the time of attendance for interview and venesection. Because there were 2731 women who were members of both cohorts this enabled a comparison of self-reported and measured heights to be conducted. Although there was a correlation between the two heights, there was considerable divergence at both extremes. Shorter women were more likely to overestimate their height, whereas taller women tended to underestimate their stature. In postmenopausal women, there was a relationship between height and risk. Within this group the trend towards a relationship between measured height and breast cancer risk ($\chi^2 = 0.09$) was markedly attenuated when self-reported height was used ($\chi^2 = 0.24$).

As a result of these findings, we have re-analysed the results of the 23 published studies on height and breast cancer risk [2]. Adding to these the study of Tavani and colleagues there have been nine which found no association between height and breast incidence and 14 which showed a positive relationship, with taller women being at higher risk. None of the negative studies were prospective compared with eight (57%) of the positive publications. Within the studies which showed no association, height was self-reported in eight (89%). In contrast, in the positive studies, only four (29%) used self-reported height as a risk factor (χ^2 (Yates correction) = 5.75, $P < 0.01$).

These findings suggest that misreporting of extremes of height may be a common human failing. Whether this has any gender basis cannot be determined from these results. Certainly we should not underestimate the impact of personal feelings about being too short or too tall in terms of inaccuracy of self-reporting of height in those who perceive themselves as having stature outside of the 'normal' range. Adult height will depend upon a variety of both genetic and environmental factors. Interestingly, a recent study has suggested that women with *BRCA-1* mutations were more likely to have low birth weight and length [3]. This effect was present in women born between 1936 and 1971, suggesting that this was unaffected by changes in nutrition. Hence, it is possible that the increased risk associated with height is a marker of environmental exposure to both nutrients and carcinogens. Future epidemiological studies examining risk factors should avoid self-reported height estimates and rely instead upon objective measurement of stature.

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The EORTC Phase II Study of Iproplatin in Advanced Osteogenic Sarcoma

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OSTEOSARCOMA OF the extremities, recognised usually as a high grade tumour, affects mainly children and young adults. During the last few decades, the introduction of aggressive cisplatin-based combination chemotherapy has dramatically improved long term survival to 65% [1]. Iproplatin (*cis*-dichloro-*trans*-dihydroxy-bis(isopropyl-amin)platinum IV) was introduced in the 1980s as a new second generation platinum compound, which had shown less nephro- and neurotoxicity than cisplatin in preclinical studies and phase I trials [2,3]. Early results suggested moderate activity of the drug in several tumours, even if these were considered as chemorefractory [4–6]. In this study, iproplatin was evaluated in the treatment of advanced and relapsing osteosarcomas.

Patients with histologically proven, measurable, pretreated metastatic osteosarcoma were investigated in this study. The other eligibility criteria were: patients' informed consent, WHO performance status ≤ 2 , age 5–55 years, as well as adequate renal, liver and haematological function tests (white blood cell count (WBC) $> 4.0 \times 10^9/l$, platelet count $> 125 \times 10^9/l$). Pretreatment investigations included a complete medical history, physical examination, laboratory data (haemoglobin, WBC and platelet count, clinical chemistry),

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